



Statewide Emergency Medical Services (EMS) System

Pandemic Influenza Response Toolkit

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CONTENTS

Introduction & Purpose	1
Situation & Assumptions.....	2
Basic Plan	3
Command & Control	12
Logistics	12
Staff Safety & Health.....	14
Public Information & Risk Communication.....	14
Demobilization.....	14

Appendix A: EMS System Actions by Severity Level

Appendix B: EMS/PSAP Planning & Preparation

Appendix C: Infection Control Procedures

Appendix D: Summary of Statutory, Regulatory and
Protocol Provisions Affecting EMS Pandemic
Response

SECTION 1.0: INTRODUCTION & PURPOSE

1.1 INTRODUCTION

Severe influenza pandemics represent one of the greatest potential threats to public health in the United States. Pandemics are distinct from normal seasonal influenza epidemics and from most other types of public health emergencies. Unlike natural disasters, where disruption is likely to be infrastructure-related, operational disruption during a pandemic is largely human and materiel related.

An influenza pandemic has the potential to cause illness in a very large number of people, overwhelm the health care system, and jeopardize services by causing high levels of absenteeism in the workforce. Basic services, such as health care, law enforcement, fire, emergency management, communications, transportation, and utilities may be disrupted during a pandemic.

The continued function of our statewide Emergency Medical Services (EMS) system is critical to minimizing the impact of a pandemic. This toolkit outlines actions HEALTH and its EMS system partners may take to ensure the continued availability of EMS services in Rhode Island.

IMPORTANT NOTE: This toolkit outlines the steps that will **likely** be taken in response to a pandemic event. However, **no part of this document alters or supersedes any existing laws, regulations, or protocols.** Any such changes **must** come in the form of Special Order(s) issued by HEALTH at the time determined by Health. **ALL EXISTING LAWS, REGULATIONS, AND PROTOCOLS REMAIN IN FULL FORCE AND EFFECT UNTIL SPECIFICALLY ALTERED BY A SPECIAL ORDER FROM HEALTH.**

1.2 PURPOSE

The overarching goal of the state's pandemic response will be to minimize the morbidity and mortality of the pandemic by preparing the public, slowing transmission of disease, and working to preserve the functionality of basic infrastructure.

The statewide EMS pandemic toolkit supports this goal by delineating a process to maximize the utilization of, and ensure the continued availability of, EMS resources during a pandemic. The toolkit is intended to work in concert with the Rhode Island Department of Health (HEALTH)'s Pandemic Influenza Plan, Rhode Island's *Major Incident* EMS protocol, other state agencies' plans, and related local plans. Each Rhode Island EMS service/department is expected to use this system-wide toolkit as the basis for further development of department-specific plans.

1.3 SCOPE

This toolkit is applicable to all Rhode Island licensed ambulance services and includes all functions of the statewide EMS system as related thereto. These functions include:

- Dispatch;
- Triage;
- Patient treatment;
- Equipment;
- Transportation;
- Destination.

For purposes of pandemic planning, the partners comprising Rhode Island's EMS system include:

- RI E-911 Uniform Emergency Telephone System (E-911);
- Local public safety answering points (PSAPs);
- Ambulance/EMS services;
- Hospital facilities;
- RI Department of Health (HEALTH).

This document describes the general statewide EMS response to any pandemic influenza event. During an actual event, this toolkit will be augmented by event-specific Special Orders and directives from HEALTH. Special Orders from the Director of Health may alter or supersede existing laws, regulations, and protocols as necessary to ensure an effective EMS response to the emergency. **UNTIL SUCH A SPECIAL ORDER IS ISSUED BY HEALTH, ALL EXISTING LAWS, REGULATIONS, AND PROTOCOLS REMAIN IN FULL FORCE AND EFFECT.**

SECTION 2.0: SITUATION & ASSUMPTIONS

2.1 SITUATION

A novel influenza type impacts, or threatens to impact, public health in the State of Rhode Island. A public health emergency and/or a general state of emergency have been declared at the state or national level. All federal, state, tribal, and local resources are brought to bear in an effort to slow transmission of the disease and ensure the continued availability of care for medical patients.

2.2 ASSUMPTIONS

It is assumed that emergency services in Rhode Island, particularly the statewide EMS system, will become overwhelmed during an influenza pandemic. Each agency will likely have to cope not only with high rates of employee absenteeism, but exponential increases in call volumes (particularly via 9-1-1) and requests for medical aid/transport.

Hospital capacity will be similarly stressed and some form of alternative healthcare setting may be implemented. In preparation for the pandemic's hospital impact, the State has established a system of Healthcare Service Regions. The state will be divided into ten Healthcare Service Regions, each coordinated by one of the state's

acute care hospitals. Inpatient facilities may be expected to discharge patients who can be supported at home, cancel elective procedures, stand up units for the observation/isolation of newly admitted inpatients with influenza symptoms, and preserve surge capacity beds. (See 3.8 *Healthcare Service Regions* for further detail.)

This scenario will present unique challenges to Rhode Island's statewide EMS system.

2.3 PLAN DEVELOPMENT & PROMULGATION

2.3.1. Leadership & responsibility

The lead agency for this toolkit is the Rhode Island Department of Health (HEALTH) in cooperation with representatives from the following:

- Rhode Island Emergency Management Agency (RIEMA);
- RI E-911 Uniform Emergency Telephone System (E-911);
- Rhode Island commercial ambulance services;
- Rhode Island Association of Fire Chiefs (RIAFC);
- Rhode Island Metropolitan EMS Association;
- Hospital Association of Rhode Island (HARI);
- US Department of Health and Human Services (HHS).

2.3.2. Toolkit maintenance

HEALTH will review this document yearly as well as any time a specific, credible health threat is identified that could precipitate its use. Any updates will be promulgated to EMS services and other stakeholders in either electronic or hardcopy format.

To ensure the efficacy of the guidance contained herein, HEALTH will engage Subject Matter Experts (SMEs) from the EMS community (including EMS providers, hospital facilities, E-911, and PSAPs) to review changes and suggest improvements.

2.3.3. Notifications during activation

During a pandemic response, notifications and Special Orders related to the pandemic response will be promulgated to EMS providers as described in 3.2 *Activation, notification & alert*.

SECTION 3.0: BASIC PLAN

3.1 CONCEPT OF OPERATIONS

During a pandemic event, HEALTH will monitor the impact on the statewide EMS system to determine what actions, if any, are necessary to ensure the continued availability of EMS service in the state. When necessary, HEALTH will issue Special Orders that supersede or suspend various aspects of patient care protocols and/or regulatory requirements as needed to ensure continued functioning of the statewide EMS

system. When issued, these directives will allow EMS services to modify their normal operations in response to changing conditions.

To the greatest extent possible, the statewide pandemic response will build on existing practices and infrastructure rather than creating new ones. This allows responders to continue working within structures they're familiar with rather than having to become acquainted with new ones during a period of high operational stress.

3.2 ACTIVATION, NOTIFICATION & ALERT

HEALTH will implement this toolkit upon recognition that a pandemic event is impacting, or threatens to impact the state, affecting the statewide EMS system. During such times, EMS service leaders should regularly monitor communications from HEALTH and other agencies for information and alerts. **NOTE: Implementation of this toolkit does not automatically trigger any statutory, regulatory, or protocol changes. All existing laws, regulations, and protocols remain in full force and effect until specifically altered by a Special Order from HEALTH as described elsewhere in this plan.**

HEALTH will post on its web site and in WebEOC any written orders, notifications, etc. related to the pandemic response and this toolkit. EMS system partners will then be alerted to these postings as follows:

- To all HEALTH EMS email list subscribers via email blast (all ambulance service chiefs/coordinators);
- To hospital emergency departments via the Hospital NEXTEL network and/or the web-based Hospital Capacity System (HCS);
- To RIEMA, HARI, E-911 and other partners via individual telephone and/or email.

3.3 SPECIAL ORDERS

As described in this document, , HEALTH will monitor current conditions to determine what steps are necessary to ensure an effective statewide EMS response to the pandemic. HEALTH will then issue Special Orders that modify or suspend specific regulations and protocols as needed to accomplish these steps. Such Special Orders will generally be statewide and applicable to all EMS providers. However, unique circumstances may require Orders that are specific to a particular service or locale.

3.3.1. Legal Authority

The authority to issue such Special Orders may be derived from one or more of the following:

- Existing provisions of the *Rhode Island Pre-Hospital Care Protocols and Standing Orders* (with specific reference to the *Major Incident* protocol);
- Existing provisions of the *Rules and Regulations Pertaining to Emergency Medical Services (R23-4.1-EMS)*;
- HEALTH's statutory authority over the statewide EMS system as described in Chapter 23-4.1 of the Rhode Island General Laws;

- An Executive Order issued by the Governor under the provisions of Rhode Island General Laws §30-15-9(b).

3.4 EVENT SEVERITY

Several scales are commonly used at the international, national, and state levels to indicate the current status of a pandemic event (e.g., the World Health Organization [WHO] Pandemic Influenza Phases.) Most of these scales describe the event from an epidemiological standpoint but do not reflect the event's actual impact on elements of the healthcare system.

Accordingly, HEALTH will measure the statewide impact of a pandemic on EMS functions using the Dynamic Event Severity Scale, as developed by the National Association of State EMS Officials (NASEMSO). This scale provides a framework for modifying response, treatment, and other EMS system functions based on the event's actual implications for EMS operations.

IMPORTANT NOTE: The EMS Dynamic Event Severity Scale measures a pandemic's impact on statewide EMS system as a whole, not at a local or individual service level.

The EMS Dynamic Event Severity Scale defines three levels of pandemic severity with respect to the EMS system (the 'Normal' level is added here for reference):

Normal: No increased activity related to pandemic, dispatch and EMS demand generally average, EMS and dispatch availability adequate, hospital capacity normal.

EMS Severity Level 1 (Mild Impact): Dispatch and EMS demand above average; EMS and dispatch personnel availability stressed; hospital capacity limited.

EMS Severity Level 2 (Moderate Impact): Demand for EMS/dispatch is very high; EMS and dispatch personnel availability is seriously low; hospital capacity exceeded; system activation of alternate patient destinations.

EMS Severity Level 3 (Severe Impact): Demand for EMS/dispatch is overwhelming; EMS/dispatch personnel availability is critically depleted; no remaining hospital capacity; all alternative out-of-hospital resources being utilized.

Because the Dynamic Event Severity Scale focuses on EMS system impact, it is important to note that the EMS Severity Level may remain 'Normal' after WHO declares a pandemic is underway.

3.5 EMS SYSTEM FUNCTIONS

The following provides a brief summary of how a pandemic is expected to affect core functions of the statewide EMS system. These are considerations **anticipated** during a pandemic event. Actual Special Orders will be disseminated by HEALTH as warranted through the course of the event.

3.5.1. Triage / Dispatch

Triage occurs both at Public Safety Answering Points (PSAPs) responsible for dispatching ambulances, and on scene. Triage will generally be affected as follows:

EMS Severity Level 1 (Mild Impact): Distinction will be made between ILI and non-ILI patients based on CDC case definition. Based on service availability, some EMS services may need to implement a tiered response model (i.e., withholding transporting ambulances/rescues until initial personnel on scene have ascertained that an ambulance transport will be required.)

EMS Severity Level 2 (Moderate Impact): Triage will focus on identifying and reserving immediate treatment for individuals having a critical need and who are likely to survive their illness. The goal would be to allocate resources in order to maximize the number of lives saved. Tiered and/or reduced EMS response will likely expand.

EMS Severity Level 3 (Severe Impact): A screening algorithm may be used to ensure that only the most severely symptomatic ILI patients receive an EMS response while optimally allocating available resources for non-ILI patients based on acuity and severity.

3.5.2. Treatment

Treatment includes assessment and care delivered by EMS personnel as well as treatment patients may be directed to self-administer when resources are scarce. Based on this toolkit, HEALTH may issue Special Orders that supersede normal protocols with respect to various aspects of EMS patient care and transport:

EMS Severity Level 1 (Mild Impact): If not necessary for life-saving efforts, HEALTH may suspend mucous/sputum-producing treatments for ILI patients to prevent the spread of respiratory infection. Ambulatory ILI patients may be directed to alternate destinations within or outside hospital facilities. (See 3.4.4 *Transportation* below.)

EMS Severity Level 2 (Moderate Impact): HEALTH may modify treatment protocols to enable and encourage ILI patients to receive care at home.

EMS Severity Level 3 (Severe Impact): As resources become scarce, certain lifesaving efforts may not be available. HEALTH may amend the normal *Biological Death* protocol such that EMTs (whether BLS or ALS) can make a presumption of death in consultation with online Medical Control.

3.5.3. Equipment

Supplies and equipment for all aspects of healthcare are likely to become scarce during an intense or prolonged pandemic event.

EMS Severity Level 1 (Mild Impact): EMTs will be expected to begin making prudent use of equipment. Managers should implement strict inventory control procedures early on. Consistent PPE procedures must be followed when encountering potential ILI patients. HEALTH will provide guidance, based on

CDC recommendations, for any use of PPE that must deviate from normal practice. (See *Appendix C: Infection Control Procedures*.)

EMS Severity Level 2 (Moderate Impact): Selective criteria may have to be adopted with respect to saving some equipment and supplies for priority use (i.e., for those patients needing them most.)

EMS Severity Level 3 (Severe Impact): In the absence of an alternative, some disposable supplies may have to be reused following appropriate decontamination (however, invasive devices will not be reused under any circumstances.) Further selective criteria will likely be required with respect to reserving scarce equipment and supplies.

3.5.4. Transportation

During a pandemic event, existing transportation practices and protocols will need to be substantially revised so as to maximize the availability of EMS assets.

EMS Severity Level 1 (Mild Impact): Non-urgent and ambulatory patients (both ILI or non-ILI) may have to walk or self-transport to the nearest care facility or hospital (**NOTE: Symptomatic ILI patients should be advised NOT to take public transportation.**)

EMS Severity Level 2 (Moderate Impact): EMS may be directed to transport all but the most acute ILI patients to alternate destinations (e.g., Alternate Care Sites or quarantine/isolation locations.) It may become necessary to utilize buses and other forms of non-medical transportation to supplement emergency transport systems.

EMS Severity Level 3 (Severe Impact): As EMS resources become scarce, only the most acute patients will be transported via ambulance/rescue. All others will utilize buses and other forms of non-medical transportation as described above for Level 2.

3.5.5. Patient Destination

In conjunction with changes to transportation (above), patients will likely be transported or directed to alternate destinations during a pandemic event. The goal will be to prevent overloading hospital emergency departments with ILI patients such that urgent non-ILI patients cannot receive care.

EMS Severity Level 1 (Mild Impact): Most patients will continue to be transported according to normal practices. However, if necessary, HEALTH may alter minimum staffing and/or vehicle requirements.

EMS Severity Level 2 (Moderate Impact): Alternate Care Sites (ACS) may be opened to care for non-critical patients as well as those requiring isolation and/or hospice. Criteria will be established by HEALTH for those patients whom EMS should transport to an ACS instead of a hospital. HEALTH may also permit EMS to transport non-critical patients to non-hospital facilities such as walk-in clinics, physicians' offices, etc., when appropriate.

EMS Severity Level 3 (Severe Impact): Use of ACS sites will be expanded and criteria for patient destination may be modified depending on hospital census. If hospital capacity becomes severely depleted, emergency department access may be reserved for immediate need patients (i.e., those that would be categorized as “Critical/Red” when triaged.) Other patients would either be transported to an ACS site or refused transport and left at home with self-care instructions and/or supplies.

3.6 EMS SYSTEM ROLES & RESPONSIBILITIES

Each partner in the statewide EMS system plays a critical role in the success of this effort. During a pandemic event, their roles may generally be defined as follows. More specific roles and responsibilities are also delineated throughout this plan.

3.6.1. Dispatch and Communication Centers

Dispatch and communication centers play a critical role in every phase of EMS incident management, including those involving infectious disease pathogens. Rhode Island employs a two-step dispatch/communications process for 9-1-1 calls: emergency calls are first received at the state E-911 center in North Providence, and then relayed to the appropriate local Public Safety Answering Point (PSAP) for dispatch. The respective pandemic response roles of each may be described as follows:

Rhode Island E-911

- Receive emergency calls via the E-911 system, determine the nature of the emergency (police/fire/rescue), and route the call to the appropriate local PSAP;
- Assist local PSAPs, when possible, with determining caller location, overcoming language barriers, and re-contacting disconnected callers.

Local PSAPS

- Receive emergency calls relayed from E-911 or placed directly to the PSAP (i.e., using a normal 7- or 10-digit phone number);
- Determine resources required and initiate appropriate responses of emergency units (EMS crews, etc.);
- Identify (when possible) the potential presence of an infectious environment, advise responding units of prevailing conditions, and provide pre-arrival instructions to members of the public.
- Participate in the triage of calls and allocation of resources as indicated.

3.6.2. Ambulance Services

The majority of ambulance services in Rhode Island fall into one of two general categories: emergency (i.e., 9-1-1) services, which typically serve a given municipality, and private services, which are typically commercial enterprises. There are additionally a small number of services that may be either college/university-based (serving a given institution’s campus and student/faculty/staff population) or corporate (serving the employees of a given organization [e.g., Electric Boat in Quonset.]) During a pandemic, the relative roles of these services types may be summarized as follows:

Emergency/Municipal (9-1-1) Services

- Respond to emergency calls for pre-hospital medical assistance when dispatched by their PSAP;
- Provide emergency patient care and/or transportation (as indicated) to hospital facilities or alternate care sites, in accordance with applicable protocols, orders and standards;
- Supplement staffing (when called upon by HEALTH and subject to availability) and/or provide EMS support at healthcare facilities, including hospitals, Alternate Care Sites (ACS), and Points of Dispensing (PODs).

Private/Commercial Services

- Provide interfacility transportation of emergent and non-emergent patients between healthcare facilities (including hospitals, Alternate Care Sites (ACS), etc.);
- Coordinate with hospital facilities to facilitate rapid discharge of patients;
- Supplement local emergency/municipal ambulance services when called upon (subject to availability);
- Supplement staffing (when called upon by HEALTH and subject to availability) and/or provide EMS support at healthcare facilities, including hospitals, Alternate Care Sites (ACS), and Points of Dispensing (PODs).

College/University Services

- Provide primary/initial response to calls for pre-hospital medical assistance within the service's jurisdiction (i.e., the campus population);
- Evaluate patients to determine appropriate care and disposition in accordance with existing patient care protocols and/or any special orders issued by HEALTH;
- Request support from emergency/municipal or private/commercial EMS services when needed and as appropriate to the patient;
- Work with campus healthcare services to provide palliative care for patients who will not be transported to a hospital or ACS facility. (NOTE: The role of EMS personnel in providing such care is limited to that permitted under existing patient care protocols and/or any special orders issued by HEALTH.)

Corporate/Industrial Services

- Provide primary/initial response to calls for pre-hospital medical assistance within the service's jurisdiction (i.e., the company's facility and workforce);
- Evaluate patients to determine appropriate care and disposition in accordance with existing patient care protocols and/or any special orders issued by HEALTH;
- Request support from emergency/municipal or private/commercial EMS services when needed and as appropriate to the patient.

3.6.3. Hospital Facilities

- Receive emergent and non-emergent patients transported by EMS and provide appropriate care as indicated;
- Coordinate pandemic response activities with local EMS providers, including both emergency/municipal and private/commercial services;
- Ensure ongoing surge capacity within the hospital facility, notifying HEALTH when that capacity may be exceeded;

- When called upon by HEALTH, organize and administer resources within an assigned Healthcare Service Region (HSR);
- Open Alternate Care Site(s) when requested by HEALTH to manage additional patient volume.

3.6.4. Department of Health

- Monitor infectious disease outbreaks and global pandemic status;
- Facilitate/coordinate the overall functioning of the state's healthcare system throughout a pandemic event, including patient care standards, public messaging, and the like;
- Call for the implementation of actions (when warranted) and issue event-specific guidance to EMS system partners;
- Identify and monitor system shortfalls and barriers to effective response;
- Work with other agencies to overcome barriers and shortages;
- Issue EMS Special Orders that suspend or modify existing regulations and protocols so as to ensure the EMS system's effective response to the event.

3.7 EMS SYSTEM ACTIONS

At each level of severity during a pandemic, there are specific actions that each partner in the statewide EMS system is expected to take. These are listed in *Appendix A* as follows:

Dispatch and Communications Centers	A.1
Ambulance Services (including municipal and commercial)	A.2
Hospital Facilities	A.3
Department of Health (HEALTH)	A.4

Appendix B provides additional planning and preparation guidance specific to EMS and PSAPs.

3.8 PRIORITIES & STANDARDS

To the greatest extent possible, HEALTH will align its priorities and standards with those of the U.S. Centers for Disease Control (CDC) and those of neighboring New England states.

3.9 HEALTHCARE SERVICE REGIONS (HSRs)

Because Rhode Island has no local or county health departments, the state has developed a Healthcare Service Regions plan for use during widespread public health emergencies. Under this plan, the state will be divided into ten regions, each supported by one of the state's acute care hospitals as shown below. The assigned hospital is responsible for coordinating all healthcare assets within its defined region. Local EMS services should thus coordinate plans and activities with their local HSR; however, EMS services are not under the HSR's direct supervision. Ordinary lines of supervisory authority will remain in place (See *Section 4.0: Command and Control*.) The HSR approach is designed to help

regions overcome such burdens as limited resources and staff depletion. Further details are available in the state's HSR plans.

3.9.1. Regional HSR Designations

Landmark Medical Center	<i>Burrillville, North Smithfield, Woonsocket</i>
Memorial Hospital	<i>Cumberland, Lincoln, Central Falls, Pawtucket</i>
Fatima Hospital	<i>Glocester, Smithfield, Johnston, North Providence</i>
Roger Williams Medical Center ..	<i>Foster, Scituate, Cranston</i>
Rhode Island Hospital	<i>Providence</i>
The Miriam	<i>East Providence, Barrington, Warren, Bristol</i>
Newport Hospital	<i>Jamestown, Portsmouth, Middletown, Newport, Tiverton, Little Compton</i>
Kent Hospital	<i>Coventry, West Warwick, Warwick, West Greenwich, East Greenwich</i>
South County Hospital	<i>Exeter, North Kingstown, Richmond, South Kingstown, Narragansett</i>
Westerly Hospital	<i>Hopkinton, Westerly, Charlestown, New Shoreham</i>

3.9.2. Alternate Care Sites (ACS)

As hospital occupancy becomes stressed, HEALTH may direct HSRs to open Alternate Care Sites (ACS) that will accommodate specific categories of patients (most likely non-acute ILI patients.) Each ACS site will serve as an extension of its parent hospital facility and operate under its existing hospital license. Once ACS sites are open, EMS crews will be given guidelines as to which patients should be transported to an ACS as opposed to a standing hospital emergency department. EMS will also have a critical role in transferring patients between ACS locations and hospitals if their condition should improve or decline.

3.9.3. Vaccine and antiviral distribution

During a pandemic, HSRs are expected to play a lead role in vaccination and/or antiviral distribution for the state's healthcare workers and first responders. In addition to receiving vaccinations or antivirals themselves, EMTs may be asked to assist in staffing vaccination/antiviral distribution sites. Detailed plans for these functions will be promulgated by HEALTH as necessary. **NOTE: Vaccine administration is not part of the regular EMT scope-of-practice and requires a Special Order from HEALTH.**

3.10 SPECIAL NEEDS POPULATIONS

Populations with special needs will require particular attention during a pandemic event. Special needs individuals may have greater difficulty accessing healthcare and/or, in some cases, may be more susceptible to illness because of underlying medical conditions. The state's Special Needs Registry, maintained by HEALTH and RIEMA, is one tool that

may be helpful in identifying such local populations. However, each municipality should have its own procedures for identifying and providing for its special needs patients.

SECTION 4.0: COMMAND & CONTROL

During a pandemic event, the State of Rhode Island will function under the National Incident Management System (NIMS) and will therefore organize its incident response using the Incident Command System (ICS.) Within Rhode Island's statewide emergency management process, HEALTH is responsible for all healthcare activities under Emergency Support Function (ESF) #8 and will provide the appropriate guidance and leadership thereof. Depending on circumstances (and event severity), the State health response may be coordinated from HEALTH's Department Operations Center (DOC) or the State Emergency Operations Center (EOC) at RIEMA.

During a pandemic event, all EMS resources will remain under local/individual command and control. However, HEALTH will coordinate the statewide EMS pandemic response in accordance with its statutory responsibility to supervise the statewide EMS system. Each municipal ambulance service is expected to coordinate its operations with its designated Healthcare Service Region (HSR.)

Each ambulance service should ensure that all necessary Mutual Aid agreements and similar arrangements are in place and have been exercised prior to the beginning of a pandemic event. It should be noted that, during a pandemic event, municipal EMS systems are likely to be equally stressed and mutual aid should not be substantially relied upon to augment depleted EMS resources.

Services also need to maintain ongoing communication with HEALTH throughout a pandemic—effective coordination of the statewide EMS response depends on regular input and status reports from local services.

SECTION 5.0: LOGISTICS

5.1 EQUIPMENT & SUPPLIES

Many key healthcare consumables (supplies, medications, etc.) are likely to become scarce during an intense or prolonged pandemic event. Additionally, it may become difficult to have certain critical equipment (e.g., ventilators, cardiac monitors) serviced or repaired during such an event. Consequently, patient care standards may have to be modified at times because certain items are not available or to conserve the resources that are (see 3.4.2 *Treatment* above.) It is essential that EMS services document, as thoroughly as possible, their use of equipment and supplies during the pandemic. This information will be used for planning and other purposes.

5.1.1. Re-stocking of supplies and medications by hospitals

During a pandemic event, one-for-one restocking of supplies and medications by hospitals will continue as normal; hospitals will not be permitted to withhold items that

are in short supply. However, hospitals are under no obligation to provide additional supplies or equipment to EMS providers that request them under the mandatory exchange policy. (See below regarding distribution of supplies by HEALTH.)

5.1.2. Responsibility to stock supplies, medication, and equipment

Although hospitals will restock supplies and medications used for calls, each ambulance service is responsible for maintaining its own inventory of supplies, medication, and equipment. Services should exercise good judgment in stocking key items (e.g., gloves, masks, IV fluids, etc.) while they are still readily available. Services are also encouraged to work out reciprocal arrangements for the sharing and redistribution of any local surpluses.

5.1.3. Distribution of supplies by HEALTH

When necessary, HEALTH may distribute certain supplies (e.g., N-95 masks) from a predesignated cache or from the Strategic National Stockpile (SNS.) It is expected that such state distribution will be carried out through the Healthcare Service Regions (HSRs) or hospital emergency departments. Details about such distribution will be promulgated by HEALTH upon activation.

5.1.4. Resource requests

Ambulance services may at times have critical resource needs that they cannot fill internally. HEALTH will work with the Rhode Island Emergency Management Agency (RIEMA) to assist services in filling such requests when possible. Any such requests should be submitted through the service's associated Healthcare Service Region (HSR.)

5.2 COMMUNICATIONS

5.2.1. Voice Communications

Communications infrastructure and protocols vary among jurisdictions across the state. During a pandemic event, ambulance services will continue to utilize the systems they employ on a normal basis. These include landline and cellular telephone as well as VHF, UHF, and 800MHz two-way radio. HEALTH and RIEMA will work to ensure the continued availability of reliable systems for interagency coordination as described in:

- Rhode Island's *Statewide Communications Interoperability Plan (SCIP)*;
- HEALTH's *Healthcare Emergency Tactical Communications Plan*;
- *State of Rhode Island Hospital Diversion Plan*;
- *Southern New England Fire Chiefs Emergency Assistance Plan*.

5.2.2. Daily/weekly conference calls

To coordinate activities throughout the statewide EMS system, HEALTH will set up a daily or weekly conference call to address pandemic-related EMS issues. If appropriate, this call may be conducted in conjunction with a statewide EMA conference call or may be held as a separate call. If the EMS call is held in conjunction with an EMA conference call, private/commercial ambulance services will be invited to participate.

5.2.3. Data communications

Data communications that may be utilized to support pandemic response activities include email plus the following Web-based applications:

- **WebEOC** is a statewide web-based system used by incident managers and emergency management personnel to share information and decision-making throughout the duration of operations;
- The **Hospital Capacity System (HCS)** is used to track real-time diversion status and on-demand bed availability of hospital emergency departments in all Rhode Island hospital facilities;
- The **Patient Tracking System (PTS)**, if available, will be used by participating EMS services to track the location of all patients transported by EMS.

Details for utilizing these systems will be promulgated by HEALTH as needed.

SECTION 6.0: STAFF SAFETY & HEALTH

Each service is responsible for developing its own health and safety measures in accordance with local needs and resources. Health and safety plans should be based on guidance from HEALTH, CDC and other sources. During a pandemic event, supervisors must continually monitor staff for signs of illness or stress. Personnel should be promptly referred to medical care or mental health counseling as needed. The state's Critical Incident Stress Management team should be engaged for this purpose.

SECTION 7.0: PUBLIC INFORMATION & RISK COMMUNICATION

During a pandemic event, it is imperative that the public receives consistent information at every jurisdictional level. As the state's lead ESF #8 agency, HEALTH will be responsible for developing overall statewide messaging. Healthcare Service Regions (HSRs) will then be charged with coordinating public healthcare information within their defined areas based on HEALTH's overall guidance. All EMS services will be expected to coordinate their own public communications with their local HSR and with HEALTH. Each EMS service should designate a Public Information Officer (PIO) to work with their local HSR's PIO toward that end.

SECTION 8.0: DEMOBILIZATION

A smooth transition back to normal operations is an equally vital component of the EMS pandemic response. Demobilization occurs not just to the conclusion of a pandemic event but whenever conditions change and resources are released or reassigned. Services should be mindful that pandemic events typically occur in waves, such that a downgrade may be followed by a subsequent resurgence of activity (referred to as an "inter-pandemic period".)

8.1 DISCONTINUING EMS SPECIAL ORDERS

EMS special orders will be rescinded at the discretion of HEALTH based on an evaluation of the EMS pandemic severity level in relation to statewide operations. This information will be promulgated in the same manner as the special orders were originally disseminated (See 3.2 *Activation, Notification & Alert*.) EMS services are obligated to check regularly for any such status changes and disseminate them to their personnel immediately.

8.2 RECOVERY AND REHABILITATION

Services should make prompt use of inter-pandemic periods to restock depleted supplies, rehabilitate equipment, and provide rest for personnel. This will ensure that each service is ready to resume normal operations or respond to a subsequent pandemic wave if one should occur.

8.3 LESSONS LEARNED

Every phase of a pandemic event offers important lessons for EMS providers as to which practices are most effective and which practices do not work. At relevant points during a pandemic event, most typically during inter-pandemic periods, HEALTH will facilitate the sharing of lessons learned, both within and outside Rhode Island. The goal of this process will be encourage Rhode Island's EMS system partners to identify best practices and promulgate these throughout the state to improve performance during the next pandemic wave. The continual process of applying lessons learned will be carried out through routine conference calls during the pandemic event and system-wide "hot-washes" held during the inter-pandemic periods. HEALTH may also identify interim recommendations or advice that can be communicated to EMS system partners via email or fax.

Appendix A: EMS System Actions by Severity Level

The following describes the likely impact of a pandemic event on the partners in Rhode Island's statewide EMS system (PSAPs, ambulance services, hospitals/HSRs, and HEALTH.) It should be noted that, while hospital information is included here for reference, this plan does not supersede existing plans specific to hospitals and/or HSRs.

IMPORTANT NOTE: This document outlines the steps that will **likely** be taken in response to a pandemic event. However, **no part of this guidance alters or supersedes any existing laws, regulations, or protocols.** Any such changes **must** come in the form of Special Order(s) issued by HEALTH at the time of the event. **ALL EXISTING LAWS, REGULATIONS, AND PROTOCOLS REMAIN IN FULL FORCE AND EFFECT UNTIL SPECIFICALLY ALTERED BY A SPECIAL ORDER FROM HEALTH.**

A.1 Public Safety Answering Points (PSAPs)

The following actions are expected of Rhode Island's EMS dispatch and communication centers at each pandemic severity level:

EMS Severity Level 1 (Mild Impact)

- Continue with any unfinished items from "Planning & Preparations." (See Appendix B)
- When appropriate, query callers about potential Influenza-Like Illness (ILI) cases on the scene.
- Relay information about possible ILI to responding EMS units so that PPE may be donned prior to arrival, if indicated.
- Check availability of automated phone recordings, scripts and additional telephone resources and/or information lines for transfer. Continue referral of non-emergent calls for pandemic information to HEALTH call center (401-222-8022.)
- Advise employees to prepare for the possibility of extended deployments.
- Review Employee Protection Plan [See Appendix B], including availability and provision of anti-viral medications and vaccinations.
- Begin providing ongoing shift briefings to include:
 - Status of outbreak during previous 24 hours;
 - Status of all receiving hospitals;
 - Status of any pandemic-related Special Orders from HEALTH.
- Review plans for, and familiarize personnel with, potential transition to Level 2 operations.

EMS Severity Level 2 (Moderate Impact)

- When necessary, begin transferring calls for pandemic information and direction to alternate telephone services, if available.

- Monitor call/alarm volume and work-load. Consider implementing an alternative staffing plan for dispatchers and call takers.
- Consider screening of employees coming to work for exposure, symptoms and temperature. Also screen for indications of emotional stress and refer to counseling resources (e.g., CISM) as needed.
- Monitor employees' availability for work (based on personal and/or family illness.)
- Review facility Continuity of Operation (COOP) plans. Ensure availability of needed medical and non-medical items at stations to support extended operations.
- Review plans for, and familiarize personnel with, potential transition to Level 3 operations.

EMS Severity Level 3 (Severe Impact)

- Monitor daily instructions and direction from HEALTH.
- Activate pandemic Emergency Medical Dispatch (EMD) protocol when directed by HEALTH:
 - Transfer callers to recorded lines or other automated systems for:
 - General information
 - Information of personal hygiene
 - Patient and self care instructions
 - Locations of alternate treatment centers
 - Reporting fatalities and care of the deceased
- Implement "Reduction of Service" policies when necessary.
- Response will be according to need and availability of resources based on Special Orders from HEALTH.
- Fully activate facility COOP plan and implement alternative staffing model:
 - Secure facility.
 - Personnel may be called to report to duty for an undefined period of time.
 - Dispatch center may serve as living quarters for those on duty for extended shifts, to minimize traveling to and from home.
- Dispatch/communications center should regularly contact employee families to check status and determine needs.

A.2 Ambulance Services

Ambulance services are inherently the backbone of the statewide EMS systems. All service types (commercial, municipal, university) play distinct and important roles in the pandemic response.

The following actions are expected of Rhode Island's ambulance services at each pandemic severity level:

EMS Severity Level 1 (Mild Impact)

- Services should complete their individual pandemic response plans.
- Continue with any unfinished items from "Planning & Preparations." [See Appendix B]
- Consider screening of employees coming to work for exposure, symptoms and temperature. Also screen for indications of emotional stress and refer to counseling resources (e.g., CISM) as needed.
- Based on guidance from HEALTH and CDC, implement mandatory personal protection guidelines when responding to possible ILI patients.
- Review plans to manage increased volume of biohazard infectious waste.
- Advise employees to prepare for the possibility of extended deployments.
- Implement Employee Protection Plan:
 - Stockpile, dispense vaccination/antiviral medications as recommended and available.
- Begin providing ongoing shift briefings to include:
 - Status of outbreak during previous 24 hours;
 - Status of all receiving hospitals;
 - Updated guidance on infection control procedures and use of PPE;
 - Status of any pandemic-related Special Orders from HEALTH.
- Review plans for, and familiarize personnel with, potential transition to Level 2 operations.

EMS Severity Level 2 (Moderate Impact)

- Implement mandatory personal protection guidelines on all responses, based on guidance from HEALTH and CDC.
- Review and begin to practice individual facility COOP plans to ensure vehicle, equipment and personnel decontamination prior to entering station living quarters. Station quarters, including offices, "day room" and bunk rooms should be considered "sterile environments" with adequate decontamination of personnel required before entering. If the haz-mat environment is applied to this concept:
 - Scene is considered the "hot zone."

- Truck bays and decon areas are “warm zones.”
 - Living quarters are “cold zones.”
- Assess volume of bio-hazard, infectious waste for increased vendor pick-ups or storage.
- Implement Employee Protection Plan (vaccinations, antiviral medication as available and as recommended by HEALTH).
- Based on alarm volumes and work loads, consider implementing an alternative staffing plan.
- Begin screening employees coming to work for symptoms, temperature and exposure to ill persons.
- Continually survey employees’ availability to work (based on either personal or family illness.)
- Ensure availability of needed medical and non-medical items at stations to support sustained/extended operations.
- Patient care will be according to modified response, treatment, and transportation plans as directed by HEALTH. Such measures may include:
 - No response to minor complaints.
 - BLS response to many previous ALS calls.
 - Possible pandemic flu patients transported to designated hospital.
- Review plans for, and familiarize personnel with, potential transition to Level 3 operations.

EMS Severity Level 3 (Severe Impact)

- Monitor daily instructions and direction from HEALTH.
- **Activate pandemic Special Orders** issued by HEALTH. EMS personnel will respond, treat, and transport flu patients according to these modified protocols.
- Implement agency “facilities plan” to ensure vehicles, equipment and personnel are decontaminated cleaned before personnel enter station living quarters. A single site might be preferred, which would offer security; vehicle and equipment decontamination supplies and personal hygiene facilities. Additional storage for accumulations of biohazard infectious waste may have to be designated.
- Consider activating and staffing local/department Emergency Operations Center (EOC) to provide link to HEALTH, review new information and emerging situation and create an agency Action Plan.
- Alternate Care Sites (ACS) may be activated by HEALTH for isolation and treatment of patients. EMS personnel may be assigned to ACS sites or hospitals, depending on need.

- If called upon by HEALTH, assist in the acquisition and delivery of vaccines and anti-viral medications, depending on availability, to regional EMS partners: dispatch, fire, law enforcement and private ambulance.
- Implement alternative staffing plans.
 - Personnel may be called to report to duty for an undefined period of time.
 - Stations may serve as living quarters for those on duty for extended shifts, to minimize traveling to and from home.
- Activate family support plans.
- Monitor personnel status:
 - On-duty
 - Off-duty
 - ILI

A.3 Hospitals

During a pandemic event, hospitals play an expanded role in local healthcare in addition to managing their own increased patient volume. Most pandemic hospital functions are addressed in other related plan documents. However, the EMS-related actions expected of hospitals during a pandemic include:

EMS Severity Level 1 (Mild Impact)

- Monitor daily instructions and direction from HEALTH.
- Review any pandemic-related EMS guidance or Special Orders issued by HEALTH.
- Confirm and test communication systems with EMS vehicles and dispatch centers, including the four regional centers.
- Provide staff with specific pandemic training and continuing education as required, including familiarization with guidance given to EMS.
- Review plans for, and familiarize personnel with, potential transition to Level 2 operations.

EMS Severity Level 2 (Moderate Impact)

- Coordinate EMS online Medical Control guidance to determine patient destinations when necessary.
- Prepare “Surge Capacity.”
- Begin to physically prepare the Alternate Care Sites (ACS) for activation in Level 3.
- Review plans for, and familiarize personnel with, potential transition to Level 3 operations.

EMS Severity Level 3 (Severe Impact)

- Cancel all elective surgeries and immediately discharge all possible patients.
- Activate individual hospital facilities plan and security; prevent public entry without passing through a triage/screening checkpoint.
- Ensure all staff receive latest pandemic-related EMS guidance and Special Orders issued by HEALTH.
- Divert appropriate ILI patients to Alternate Care Sites (ACS), if activated.
- Keep hospital status up-to-date in the Hospital Capacity System (HCS.)

A.4 Department of Health (HEALTH)

The Rhode Island Department of Health has overarching responsibility for coordinating the statewide response to a pandemic as well as specific responsibility for supervising the statewide EMS system. During a pandemic event, HEALTH will be expected to take the following EMS-related actions at each severity level:

EMS Severity Level 1 (Mild Impact)

- Inform and educate EMS providers through regular briefings, conference calls, and other channels.
- Provide periodic situation reports to EMS services for distribution to stations/bases and personnel. (NOTE: These may be in the form of general “Provider Briefings” distributed to all healthcare personnel.)
- Review plans for, and familiarize personnel with, potential transition to Level 2 operations.

EMS Severity Level 2 (Moderate Impact)

- Work with Healthcare Service Regions (HSRs) to physically prepare the Alternate Care Sites (ACS) for activation in Level 3.
- Begin distribution of vaccine and medications in accordance with plans.
- Review existing EMS protocols and guidance and issue pandemic-related Special Orders as necessary.
- Review plans for, and familiarize personnel with, potential transition to Level 3 operations.

EMS Severity Level 3 (Severe Impact)

- Implement Alternate Care Sites (ACS) based on size and distribution of patient load.
- Direct EMS transport of appropriate ILI patients to Alternate Care Sites (ACS) in order to prevent overload of regular hospital facilities and to isolate these patients from others with non-pandemic illness or injury.
- Prepare and distribute additional pandemic-related Special Orders as needed.

Appendix B: EMS/PSAP Planning & Preparation

The following are general guidelines to assist EMS services and PSAPs ensure their readiness for a pandemic event. The focus of these steps should be on ensuring continuity of operations (COOP) for all EMS services. Guidelines for other EMS system partners (hospitals, HEALTH, E-911) are provided in other documents specific to their functions.

NOTE: Once initial preparations are complete, organizations should revisit these steps annually and once an actual pandemic is underway. This is because changing conditions may require revision to suit new assumptions.

B.1 Local Public Safety Answering Points (PSAPs)

Develop a communications plan to provide surveillance of call trends for Influenza-Like Illness (ILI) symptoms. If a computer-aided dispatch (CAD) system is in use, the individual calls need to be identified so that routine queries may be made to track the incidence of such calls. During a pandemic event, this information will be valuable in predicting local needs and to epidemiology staff at HEALTH.

- Develop dispatch procedures for questioning callers about potential ILI on-scene, based on current case definitions from HEALTH and CDC.
- Relay information about possible ILI to responding EMS units so that PPE may be donned prior to arrival, if appropriate.

Consider developing a system to provide automated information to callers in the event of an overwhelming pandemic. This information may be provided by reading prepared and approved scripts or by transfer to a recorded message. The possible scenarios for requested information will include:

- Directions to any other available information lines (HEALTH, 211, etc.);
- General infectious disease/pandemic information;
- Personal hygiene;
- Self-care and care of any ill patients;
- Directions to any alternate care facilities;
- Reporting fatalities and care of the deceased.

Prepare educational materials for dispatch personnel:

- Provide in-service trainings or a self-paced online tutorial with general information about seasonal, avian, and pandemic flu;
- Written information/guidelines on new flu questions;
- This plan and how it affects dispatch.

Develop an Employee Protection Plan:

- Update emergency contact info for each employee;
- Define mutual expectations (“You take care of us, we’ll take care of you”);
- Determine employee/family needs (letter, survey);
- Masks, gloves, wipes, educational information, etc.

Determine dispatch/communications center facilities plan:

- Security and access to ensure “operations continuity”;
- Equipment needs (masks, hand wipes, etc.);

- Non-equipment needs for a pandemic (e.g. food, toiletries, bedding for stations in the event that the dispatch center is used as temporary housing for employees);
- Alternate staffing models (for example, consider longer shifts so there will be less travel to and from home);
- Screening for employees coming to work (temperature, symptoms, etc.)

Employees with suspected pandemic influenza should not remain at work and should return only after their symptoms resolve and they are physically ready to return to work. Establish policies and procedures for employee sick leave absences unique to a pandemic environment, which are non-punitive and liberal. Employee absenteeism may result from being sick themselves; caring for ill family members; or exposure to known or suspected ill individuals.

B.2 Ambulance Services

Educate all EMS personnel, including reserve personnel that may be asked to serve during times when staffing is scarce:

- Provide in-service trainings or a self-paced online tutorial about seasonal, avian, and pandemic flu;
- Provide written information/presentations/online info about this plan and related special orders that are likely to be issued:
 - Employees' responsibility for utilizing personal protective equipment
 - Guidelines for wearing PPE
 - Guidelines for personal hygiene and decontamination.

Develop facilities plan to include:

- Security and access control;
- Screening for employees coming to work (temperature, symptoms, etc.).

Develop a Continuity of Operations Plan (COOP) that includes:

- Alternate staffing models (for example, consider longer shifts so there will be less travel to and from home);
- Logistical needs to support extended staffing and operations during a pandemic event.

Develop an Employee Protection Plan:

- Define mutual expectations ("You take care of us; we'll take care of you.");
- Determine employee/family needs (letter, survey).

Employees with suspected pandemic influenza should not remain at work and should return only after their symptoms resolve and they are physically ready to return to work. Establish policies and procedures for employee sick leave absences unique to a pandemic environment, which are non-punitive and liberal. Employee absenteeism may result from: being sick themselves, caring for ill family members and/or exposure to known or suspected ill individuals.

Maintain par levels of necessary work-related personal protective equipment (masks, disposable items, etc.).

Appendix C: Infection Control Procedures

During a pandemic event, Rhode Island healthcare providers (including EMS) will be expected to follow event-specific guidance issued by HEALTH and the U.S. Centers for Disease Control (CDC.) Although some details may change from one contagion to another, the following are **general** infection control procedures that EMS providers should follow during a pandemic or when encountering any suspected cases of infectious respiratory illness. Additional information may be found in the CDC's influenza web site at <http://www.cdc.gov/flu/professionals/infectioncontrol/> and the U.S. Food & Drug Administration (FDA) web site at <http://www.fda.gov/cdrh/ppe/about.html#1>.

SPECIAL NOTE: It may be possible at times, based on CDC guidance, to distinguish suspected pandemic (i.e., novel, non-seasonal) influenza patients from normal seasonal influenza patients based on clinical presentation and/or history. When this is not possible, all ILI patients should be treated as potential pandemic influenza patients.

All healthcare providers should follow universal precautions (gloves, hand washing, good hygiene) during all patient encounters and when cleaning vehicles, equipment, etc.

Personal Protective Equipment (PPE)

Specific note should be made of the following recommendations regarding use of Personal Protective Equipment (PPE.) These are general guidelines that may be superseded by more specific guidance from HEALTH during an actual pandemic.

When treating a patient that is a suspected case of pandemic (i.e., non-seasonal) influenza as defined herein, the following precautions should be followed:

- **Place a standard surgical mask on the patient, if tolerated.** If not tolerated, all EMS personnel should wear a standard surgical mask while on scene and/or while transporting a patient.
- Whenever coming into close contact with patients (i.e., during assessment or treatment), EMS personnel should wear a fit-tested disposable N-95 respirator and eye protection (e.g. goggles, eye shield), disposable non-sterile gloves, and gown. If an N-95 respirator is not available, a standard surgical mask should be used instead.

When treating a patient that is **not** a suspected case of pandemic influenza but who has symptoms of influenza-like illness (ILI), EMS should follow standard universal precautions that include the following:

- Use good respiratory hygiene;
- Use non-sterile gloves for contact with patient, patient secretions, or surfaces that may have been contaminated. Follow hand hygiene including hand washing or cleansing with alcohol based hand disinfectant after contact.

SPECIAL NOTE: While all FDA-cleared surgical N95 respirators are labeled as “single use” disposable devices, this does not mean that the respirator needs to be replaced after each patient. As there may be a limited supply of such masks, providers may re-use the N95 mask with care for preservation and minimal folding. “Single-use” refers to the fact

that such respirators are eventually discarded rather than being decontaminated and returned to inventory. However, if the respirator becomes damaged or soiled or if breathing becomes difficult, the respirator should be removed, discarded properly, and replaced with a new one. To safely discard the respirator, place it in a plastic bag and put it in a medical waste container. This should be followed by thorough hand washing.

Please note N95 respirators are not intended for patient use. Rather, a surgical mask should be placed on the patient if not medically contraindicated.

Ambulance Ventilation

- Encourage good patient compartment vehicle airflow/ ventilation to reduce the concentration of aerosol accumulation when possible. This may be accomplished by opening patient compartment windows, if possible, and operating ventilation systems.
- If present, the door between the vehicle cab and crew compartment should be kept closed during transport to limit exposure.

Cleaning Vehicles and Equipment

Flu viruses typically live outside the body for up to 2 hours. These germs spread when someone sneezes or coughs and touches something that contaminates a surface. Prevent or contain the spread of these germs by adhering to the following:

- EMS personnel should wear appropriate PPE when cleaning vehicle and equipment.
- Routine cleaning with soap or detergent and water to remove soil and organic matter, followed by the proper use of disinfectants, are the basic components of effective environmental management of influenza. Reducing the number of influenza virus particles on a surface through these steps can reduce the chances of hand transfer of the virus. Influenza viruses are susceptible to inactivation by a number of chemical disinfectants readily available from consumer and commercial sources.
- After the patient has been removed and prior to cleaning, the air within the vehicle may be exhausted by opening the doors and windows of the vehicle while the ventilation system is running. This should be done outdoors and away from pedestrian traffic. Routine cleaning methods should be employed throughout the vehicle and on non-disposable equipment.
- Wash linens (bed sheets and towels) in regular laundry detergent. Dry on the hottest setting the fabric can tolerate. Avoid “hugging” dirty laundry before washing it to prevent spreading the germs. Clean hands with soap and water or alcohol-based hand gel after handling dirty laundry.

Exposure Reporting

The need to document potential infectious disease exposure relates **ONLY** to circumstances where the recommended precautions were not observed during patient contact. Reporting of suspected pre-hospital infectious disease exposure is required by R.I.G.L. 23-4.1-9. However, so long as appropriate precautions are followed, encounters with potentially infectious patients are **NOT** considered reportable incidents.

Additional Information Resources

- CDC WebSite: *<http://www.cdc.gov>*
- Rhode Island Department of Health Web Site: *<http://www.health.ri.gov>*
- WHO Web Site: *<http://www.who.int/en/>*

Appendix D: Summary of Statutory, Regulatory and Protocol Provisions Affecting EMS Pandemic Response

Based on the actions described in this document, it is expected that the following areas of Rhode Island EMS statute, regulation and protocol will likely need to be addressed (modified, suspended, or augmented) by HEALTH during an influenza pandemic:

Minimum staffing requirements	Defined in the <i>Rules and Regulations Pertaining to Emergency Medical Services (R23-4.1-EMS)</i>
Vehicle licensure requirements	Defined in the <i>Rules and Regulations Pertaining to Emergency Medical Services (R23-4.1-EMS)</i> and RIGL § 23-4.1-6 <i>Licensing of ambulances and ambulance services.</i>
Patient destination options	Established in various protocols within the <i>Rhode Island Prehospital Care Protocols and Special Orders.</i>
EMT scope-of-practice	Defined in the <i>Rules and Regulations Pertaining to Emergency Medical Services (R23-4.1-EMS)</i> and the <i>Rhode Island Prehospital Care Protocols and Special Orders.</i>
Documentation/reporting requirements	Described in the <i>Rhode Island Prehospital Care Protocols and Special Orders</i> , specifically the <i>Standard Management of All Patients</i> and the <i>Major Incident</i> protocol (reduced documentation is already provided for but should be articulated in a specific directive when it becomes appropriate)
Biological death	Described in the <i>Rhode Island Prehospital Care Protocols and Special Orders</i> , specifically the <i>Biological Death</i> protocol (definitions may require modification, “presumption of death” criteria may need to be added)
Hospital supply/medication exchange	Requirement defined by RIGL § 23-4.1-7.1 <i>Restocking of municipal ambulance supplies.</i>